DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 0 1 — 0 0 5

2. STATE: Minnesota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 10, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.40(b) & 441.55

7. FEDERAL BUDGET IMPACT:
a. FFY '01 $ 777.7
b. FFY '02 $ 1989.8

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 3.1-A, pp. 17-17gg
Att. 3.1-B, pp. 16-16gg
Att. 4.19-B, pp. 8-8c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att. 3.1-A, pp. 17-17w
Att. 3.1-B, pp. 16-16w
Att. 4.19-B, pp. 8-8b

10. SUBJECT OF AMENDMENT:
EPSDT Services

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Ann Berg for

13. TYPED NAME:
Mary B. Kennedy

14. TITLE:
Medicaid Director

15. DATE SUBMITTED:
May 25, 2001

16. RETURN TO:
Stephanie Schwartz
Minnesota Department of Human Services
Federal Relations Unit
444 Lafayette Road North
St. Paul, Minnesota 55155-3853

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:
~~6/1/01~~

18. DATE APPROVED: 12/21/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 10, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
Cheryl A. Harris

21. TYPED NAME:
Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

**From:** "Kennedy, Mary" <Mary.Kennedy@state.mn.us>
**To:** "'CMS:Thomas Hamilton'" <THamilton@cms.hhs.gov>
**Date:** 12/10/01 5:23PM
**Subject:** Minnesota State Plan for Children's Mental Health hc

One of the fun side benefits of the NASMD executive committee mtgs with CMS is that we can all do extra work on the side! Thomas I am asking you to look at the attached , so we can discuss on Wednesday. We are being asked to carve out DD or related conditions children from a mental health rehab proposal. Dually diagnosed children or children with "related conditions " like cerebral palsy or autism are able to benefit from mental health interventions and we should not be discriminating on the basis of diagnosis.

This amendment is also holding up our HCFA 64 claiming as we are taking CMS' directive about not claiming for pending federal claims seriously.

<<TN 01 05 argument.wpd>>

**CC:** 'CMS Teresa Pratt' <TPratt@cms.hhs.gov>

**Minnesota's State Plan Amendment on Children's Mental Health Under the Rehab Option**

- TN 01-05 was submitted in May of 2001, is still unresolved, and must resolved ASAP because:

  -CMS shouldn't need more time on this issue
  -Children aren't getting services while this SPA is pending; and
  -Further delays of this SPA creates further cash flow crises for Minnesota, because of other SPAs pending "behind" this one.

- The services: The SPA adds a new component to Family and Community Support Services, which is a package of mental health services available under the Rehab Option for children with severe emotional disturbances. The new component is behavioral aide services, designed to provide basic skills training, social skills training, redirection and other supports. We had found in the past that many children with SED were heavy users of personal care assistant services who were not trained to meet the mental health needs of these children. This additional service is designed to more appropriately meet their needs.

- On the 89th day of CMS' review, it "stopped the clock" with a request for additional information. We had a telephone conference last Friday, 12/7 and resolved all but one of CMS' concerns.

- During the pendency of this state plan, CMS issued new instructions prohibiting a state from claiming FFP for services provided under authority of a state plan that was pending and not yet approved. This new policy regarding claiming FFP is based on the assumption that decisions by CMS on state plan amendments would be streamlined. That is clearly not happening here. We have four amendments that are "hung up" while we wait for approval on 01-05.

**The Substantive Issue**

primary diagnosis POC

Cannot rehab MR

- The behavioral aide service is designed as a mental health service, which we plan to provide to all children who meet the medical need criteria. We did not "carve out" a group of SED children who could not receive this service based on the co-occurrence of developmental disabilities. According to Linda Peltz (D&EHPG), states cannot provide rehabilitative services under the state plan to children who have conditions that qualify as mental retardation or as related conditions, because for those children, the services could not be considered "restorative." Instead, the services would be viewed as helping children obtain new skills, as opposed to restoring capabilities that had been lost.

- Ms. Peltz cites a 1986 case in Ohio, and the State Medicaid Manual definition of MR/RC as authority for this position.

- Minnesota's proposal is vastly different from the Ohio proposal decided by the courts in 1986.

In that case, Ohio had proposed a package of services targeted to individuals with MR and related conditions to be covered under the rehab option. CMS disapproved the amendment and the court basically supported CMS' position (although it was remanded for some factual issues and apparently settled out of court). Minnesota is proposing a package of services targeted at SED children, and resisting the demand from CMS that we carve out those SED children who also happen to have MR or a related condition, or who have a condition like autism that can be considered both a mental illness and a related condition.

**Arguments**

- The distinction between habilitation and rehabilitation as obtaining skills versus restoring lost skills has very little meaning when dealing with young children. It especially does not make sense to not provide necessary services to a child who has an "acquired" deficit in functioning related to a mental illness because that child also carries a diagnosis of MR or a related condition.

- Carving out dually diagnosed children, or children with a condition that is considered both MR and MI, violates comparability. In the only written authority from CMS that we could find on the scope of the rehab option, a Regional Office letter from 1992, CMS clearly provides that states cannot limit the scope of a rehab option service to certain diagnoses, because of the comparability requirements of 42 CFR 440.240.

- Most states do not design services under the rehab option and then carve out all those who would be eligible but for their diagnosis of MR/RC. We've looked at many state plans. If this is CMS policy, it is a new one. And it will be very controversial.

- It is false to assume that Minnesota can meet the needs of dually diagnosed children by providing habilitative services under a waiver. Many SED children eligible under the state plan would not meet waiver level of care requirements. I also believe it is bad policy to force families to wait until their child falls to that level of need before services are available.

- This policy, if sustained, creates institutional bias and contradicts the Executive Order on ADA issues.

- Most importantly, CMS must make a decision fast on this issue, because of the backlog of Minnesota's plans that are otherwise approvable that are in line behind this one.

- We are very prepared, however, to appeal a disapproval on this issue–it is a very important issue.

Minnesota Department of **Human Services**

May 25, 2001

Cheryl A. Harris
Associate Regional Administrator
Division of Medicaid and Children's Health
Health Care Financing Administration
233 No. Michigan Avenue #600
Chicago, IL 60601-5519

**RE: TN 01-05**

Dear Ms. Harris:

The Department submits proposed State plan amendment TN 01-05 adding four elements to mental health rehabilitative family community support services in the EPSDT section of Minnesota's Medicaid State plan: 1) mental health crisis intervention and crisis stabilization services; 2) mental health services provided by mental health behavioral aides; 3) therapeutic components of preschool programs; and 4) therapeutic components of therapeutic camp programs. The State plan amendment also makes other changes, described later in this letter.

Family community support services are provided by mental health professionals or mental health practitioners and are designed to help children to function and remain with their families in the community. These services improve a child's emotional or behavioral functioning and reduce the risk of more costly out-of-home placement. In adding the four new elements, the legislature recognized the importance of providing appropriate rehabilitative services to allow children with severe emotional disturbance (or serious and persistent mental illness if between ages 18 and 21) to remain in their communities.

The specifics of each new element are discussed below.

1. <u>Mental health crisis intervention and crisis stabilization services</u>

The Minnesota State plan covers crisis assistance. This service focuses on preventing a mental health crisis by identifying factors that cause a child to experience an abrupt or substantial change in functioning, indicated by a sudden change in the child's behaviors. It also includes planning for crisis intervention and counseling services. It need not be face-to-face.

In contrast, the proposed mental health crisis intervention and crisis stabilization services are face-to-face short-term services provided by a mobile crisis response team. The services do not focus on prevention or planning, but on immediate ways to de-escalate a crisis situation. Clinically appropriate assessments and decisions are made quickly by experienced team members.

Mental health crisis intervention and crisis stabilization services are different than situations requiring medical services when there are physical threats to a child. In those cases, care is provided in an urgent care or emergency room setting.

Proposed State plan language requires at least one member of the mobile crisis response team to provide on-site intervention and stabilization services. This allows the other member(s) of the team to provide other necessary services–for example, supports to a child's family. Although services may be provided to a child's family (in addition to the child), current language on page 17x of Attachment 3.1-A and on page 16x of Attachment 3.1-B requires that family community support services be directed exclusively to the treatment of the recipient.

2. Mental health services provided by mental health behavioral aides (MHBAs)

The one-to-one services and support provided by MHBAs help a child with severe emotional disturbance and his or her family complete goals and objectives identified in the child's treatment plan in order to restore basic skills necessary to independently function in the community.

By creating the MHBA element of family community support services, the legislature acknowledged that the mental health needs of children with severe emotional disturbance can be appropriately met without requiring the services of more costly mental health practitioners or mental health professionals.

This new element is a service. Mental health behavioral aides are not added to the list of family community support services providers. Mental health behavioral aide services are the responsibility of mental health rehabilitative service providers, which are entities "operated by or under contract to" a county (for example, outpatient hospitals, community mental health centers and community mental health clinics). Please refer Attachment 3.1-A, page 17j and Attachment 3.1-B, page 16j.

Mental health behavioral aides will assist with skill development in some activities of daily living, help with task completion, and observe and intervene to redirect inappropriate behavior.

The MHBAs teach children and their families to do tasks for themselves by teaching skills, by coaching and by modeling change that a mental health professional has documented in an individual treatment plan. Mental health behavioral aides provide services required by mental health professionals and mental health practitioners as noted in a child's individual behavior plan.

Mental health behavioral aides will also provide intense mental health rehabilitative services, focusing on tools to allow a child to acquire developmentally and therapeutically appropriate skills such as: age-appropriate self-management skills as related to severe emotional disturbance, de-escalation techniques, and assisting parents to develop and use skills (when the skills are directed exclusively to the treatment of the child).

Mental health behavioral aide services are provided in a child's home, preschool, school, day care, and other community or recreational settings. In settings where mental health services are already covered—residential treatment settings, group homes, acute care hospitals, and foster care settings–MHBA services are not covered.

3. Therapeutic components of preschool programs

Therapeutic components of preschool programs are intervention services: individual or group psychotherapy provided by mental health professionals, and activities included in a child's individual treatment plan or individual behavior plan. Early intervention identifies the needs and strengths of a child and the child's family, and educates and trains them in skills and strategies to reduce and resolve the symptomology of a child's emotional disturbance.

Recreation therapy and socialization therapy are considered therapeutic components of preschool programs. The goal of rehabilitative services is to restore basic skills necessary to independently function in the community, and recreation therapy, socialization therapy, and independent living skills therapy are medically necessary components. Similar to the therapeutic camp programs, interactions that allow for socialization and independent living skills are with peers who may or may not have severe emotional disturbance. This ensures that a child interacts with the same people he or she will encounter in the community.

4. Therapeutic components of therapeutic camp programs

Therapeutic components of camp programs are early intervention services. Early intervention identifies the needs and strengths of a child and the child's family, and educates and trains them in skills and strategies to reduce and resolve the symptomology of a child's emotional disturbance. As with therapeutic components of preschool programs, this service takes place in a setting different from a child's usual environment, adding elements to skill development that strengthen a child's ability to function in a variety of community settings.

Recreation therapy and socialization therapy are considered therapeutic components of camp programs. The goal of rehabilitative services is to restore basic skills necessary to independently function in the community, and recreation therapy, socialization therapy and independent living skills therapy are medically necessary components. As with preschool programs, interactions that allow for socialization and independent living skills are with peers who may or may not have severe emotional disturbance. This ensures that a child is interacting with the same people he or she will encounter in the community.

Prior Health Care Financing Administration (HCFA) correspondence relating to approved State plan amendments TN 00-08 (home-based mental health services) and TN 00-10 (services provided to recipients with severe emotional disturbance residing in a children's residential treatment facility) questioned rehabilitative services that seemed to focus on social services, not medical services. HCFA policy allows coverage of rehabilitative services, whether or not they are considered "social services." In fact, Chicago Regional State Letter 46-92 provides that the following types of activities are covered under the rehabilitation option:

a. basic living skills: development and restoration of those basic skills necessary to independently function in the community, including food planning and preparation, maintenance of living environment, community awareness and mobility skills; and

b. social skills: development or redevelopment of those skills necessary to enable and maintain independent living in the community, including communication and socialization skills and techniques.

Rates

Minnesota Statutes, §256B.0626 provides methodologies for determining an appropriate rate for new Medicaid services. One methodology, the one followed in TN 01-05, is to refer to surrounding or comparable procedure codes. In setting rates for the new services of TN 01-05, the Department looked at rates for similar services. As a part of this procedure, the Department evaluated the current State plan mental health rehabilitative services, the proposed new family community support service elements and provider qualifications.

Other Changes in TN 01-05

The proposed amendment also makes these changes:

1. Attachment 3.1-A., page 17h and Attachment 3.1-B, page 16h clarify that licensed psychological practitioners and marriage and family therapists with at least two years of post-masters supervised experience may provide day treatment services for mental illness. This is the same language found in Attachments 3.1-A/B, item 13.d. (rehabilitative services–coverage of day treatment services for mental illness).

2. Attachment 3.1-A, page 17i and Attachment 3.1-B, page 16i deletes the limitation on the frequency of psychotherapy services. This change was made in recently approved State plan amendment TN 00-28.

The State plan amendment also deletes the language that allows most of the psychotherapy services to be provided if "additional coverage is prior authorized" in favor of general language that acknowledges that some psychotherapy services require prior authorization. Because the prior authorization requirements are subject to change, the Department adds general language so that the State plan need not be amended with each a change. Changes in prior authorization requirements are noted in the *State Register*, so the new language notes that psychotherapy services require prior authorization as specified in the *State Register*. This change was also made in approved State plan amendment TN 00-28.

3. Attachment 3.1-A, page 17k and Attachment 3.1-B, page 16k add that providers of family community support services offering mental health behavioral aide services must not employ MHBAs if the MHBAs do not qualify for licensure pursuant to Minnesota Statutes, §245A.04, subdivision 3d. Because of the length of subdivision 3d, it is impracticable to summarize it in the State plan. However, for State plan approval purposes, it is made a part of this cover letter as Attachment A.

4. Attachment 3.1-A, page 17x and Attachment 3.1-B, page 16x clarify that services provided by residential or program license holders are not eligible for Medicaid payment as family community support services because these license holders are eligible for Medicaid payment for mental health services provided in the facility or program.

5. Attachment 3.1-A, page 17x and Attachment 3.1-B, page 16x clarify that family community support services do not include crisis hotlines because crisis hotlines provide referral and educational services by organizations that do not come within the definition of family community support services provider.

6. Attachment 3.1-A, page 17x and Attachment 3.1-B, page 16x clarify that Medicaid will not pay for Level I and Level II mental health behavioral aide services provided at the same time.

7. Attachment 3.1-A, page 17y and Attachment 3.1-B, page 16y list the additional settings in which therapeutic support of foster care services may be provided.

8. Attachment 3.1-A, page 17ff and Attachment 3.1-B, page 16ff add mental health professionals to the list of those who may supervise personal care assistants providing PCA services identified in an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP). This is current practice.

I hope this provides you with sufficient information to approve proposed State plan amendment TN 01-05, effective April 10, 2001. If I can provide additional information, please contact Stephanie Schwartz at (651) 297-7198.

Sincerely,

Ann Berg for

Mary B. Kennedy, Medicaid Director
Assistant Commissioner Health Care

Enclosures

MINNESOTA

**MEDICAL ASSISTANCE**

Federal Budget Impact of Proposed State Plan Amendment TN 01-05

Attachments 3.1-A/B and 4.19-B: EPSDT Services

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Proposed State plan amendment TN 01-05 adds four elements to mental health rehabilitative family community support services in the EPSDT section of the State plan. The Department estimates the federal budget costs as follows:

| | FFY '01* | FFY '02 |
|---|---|---|
| **Federal share** | **$ 777,725** | **$1,989,807** |
| State share | $ 743,944 | $1,989,807 |
| Total MA Cost | $1,521,669 | $3,979,614 |

* April 10, 2001-September 30, 2001

4.b. Early and periodic screening, diagnosis, and treatment services:

- Early and periodic screening, diagnosis and treatment service is a service provided to a recipient under age 21 to detect, prevent, and correct physical and mental conditions or illnesses discovered by screening services, and to provide diagnosis and treatment for a condition identified according to 42 CFR 441.50 and according to section 1905(r) of the Social Security Act.

- Initial and periodic screenings are provided as indicated by the periodicity schedule. Inter-periodic screens are available to recipients based on medical necessity. An EPSDT service can be requested by the recipient or performed by a provider at any time if medically necessary.

- Initial face-to-face and written notifications of recipients are followed up by county agencies with telephone contacts, letters, and/or home visits. Annual or periodic written renotifications may also be supplemented by personal contacts.

The following are in excess of Federal requirements:

- Screened recipients receive a written copy of any abnormal screening findings.

The following health care not otherwise covered under the State Plan is covered for children by virtue of the EPSDT provisions of Title XIX:

**Rehabilitative services as follows:**

1. **Professional home-based mental health services** for children are culturally appropriate, structured programs of intensive mental health services provided to a child who is at risk of out-of-home placement because of the severe emotional disturbance. For purposes of item 4.b., a child eligible for home-based mental health services means a child who meets the functional criteria defined in Supplement 1 of this Attachment for purposes of targeted case management, or a child who has an emotional disturbance and who meets one of the following criteria:

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

A. the child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance;

B. the child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact;

C. the child has one of the following as determined by a mental health professional:

1. psychosis or a clinical depression;
2. risk of harming self or others as a result of an emotional disturbance; or
3. psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or

D. the child, as a result of an emotional disturbance, has significantly impaired home, school or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

The services are for the purposes of resolving an acute episode of emotional disturbance affecting the child, reducing the risk of the child's out-of-home placement, reunifying and reintegrating the child into the child's family after an out-of-home placement. The services are provided primarily in the child's residence but may also be provided in the child's school, the home of a relative of the child, a recreational or leisure setting or the site where the child receives day care.

A child (under age 21) is eligible for home-based mental health services, based on the results of a diagnostic assessment conducted or updated by a mental health professional within the previous 180 days. The diagnostic assessment must have determined that the child meets the functional criteria

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

outlined, above, and is in need of home-based mental health services.

The following entities are eligible to provide home-based mental health services:

A. outpatient hospitals;
B. community mental health centers;
C. community mental health clinics;
D. an entity operated by or under contract to the county to provide home-based mental health services. A contracting entity cannot assign any contractual rights or obligations to a third party who is not an employee of the entity; and
E. an entity operated by or under contract to a children's mental health collaborative to provide home-based mental health services. A contracting entity cannot assign any contractual rights or obligations to a third party who is not an employee of the entity.

A provider of home-based health services must be capable of providing all of the components specified below. However, a provider is responsible to provide a component only if the component is specified in a child's individual treatment plan. Component A is covered as a mental health service under items 2.a, 5.a., 6.d.A. and 9 of this Attachment. Components B and C are covered as professional home-based therapy services.

A. diagnostic assessment;

B. individual psychotherapy, family psychotherapy, and multiple-family group psychotherapy; and

C. individual, family, or group skills training that is designed to improve the basic functioning of the child and the child's family in the activities of daily and community living, and to improve the social functioning of the child and the child's family in areas important to the

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

child's maintaining or re-establishing residency in the community. For purposes of this item, "community" means the child's residence, work, school, or peer group. The individual, family, and group skills training must:

1. consist of activities designed to promote skill development of both the child and the child's family in the use of age-appropriate daily living skills, interpersonal and family relationships, and leisure and recreational services;

2. consist of activities ~~which~~ that will assist the family to improve its understanding of normal child development and to use parenting skills that will help the child achieve the goals outlined in the child's individual treatment plan; and

3. promote family preservation and unification, community integration, and reduced use of unnecessary out-of-home placement or institutionalization of eligible children.

To be eligible for ~~MA~~ medical assistance payment, the provider of home-based mental health services must meet the requirements in items A ~~to~~ through F, below.

A. the service under component B, above, must be provided by a mental health professional skilled in the delivery of mental health services to children and their families.
B. the services under component C, above, must be provided by mental health professionals and mental health practitioners ~~who are~~ skilled in the delivery of mental health services to children and their families.
C. the services must be designed to meet the specific mental health needs of the child according to the child's individual treatment plan that is developed by the provider and that specifies the treatment goals and objectives for the child.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

D. the provider must provide, or assist the child or the child's family in arranging crisis services for the child and the family of a child ~~which~~ that must be available 24 hours per day, seven days a week.

E. the caseload of a home-based mental health service provider must be of a size that can reasonably be expected to enable the provider to meet the needs of the children and their families in the provider's caseload and permit the delivery of the services specified in the children's individual treatment plans.

F. the services must be coordinated with the child's case manager for mental health services if the child is receiving targeted case management services.

Payment is limited to the following components of home-based mental health services:

A. diagnostic assessment

B. individual psychotherapy, family psychotherapy, and multiple-family group psychotherapy

C. individual skills training, family skills training, and group skills training

D. time spent by the mental health professional and the mental health practitioner traveling to and from the site of the provision of the home-based mental health services is covered up to 128 hours of travel per client in a six month period. Additional travel hours may be approved as medically necessary with prior authorization.

The services specified in A through J below are **not** eligible for ~~MA~~ medical assistance payment:

A. family psychotherapy services and family skills training services ~~are not covered~~ unless the services provided to the family are directed exclusively to the treatment of the recipient. Medical assistance coverage of family psychotherapy services and family skills training services is limited to face-to-face sessions at which the recipient is present throughout the therapy session or skills development session, unless the mental health professional or

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

practitioner conducting the session believes the recipient's absence from the session is necessary to carry out the recipient's individual treatment plan. If the recipient is excluded, the mental health professional or practitioner conducting the session must document the reason for the length of time of the exclusion.

B. home-based mental health services provided to a child who at the time of service provision has not been determined to be a child eligible for home-based mental health services except for the first 30 hours of home-based mental health services provided to a child who is later determined to meet the functional criteria.

C. more than 192 hours of individual, family, or group skills training within a six-month period, unless prior authorization is obtained.

D. more than a combined total of 48 hours within a six month period of individual psychotherapy and family psychotherapy and multiple-family group psychotherapy except in an emergency and prior authorization or after-the-fact prior authorization of the psychotherapy is obtained.

E. home-based mental health services that exceed 240 hours in any combination of the psychotherapies and individual, family, or group skills training within a six month period. Additional home-based mental health services beyond 240 hours are eligible for ~~MA~~ medical assistance with prior authorization.

F. psychotherapy provided by a person who is not a mental health professional.

G. individual, family, or group skills training provided by a person who is not qualified, at least, as a mental health practitioner and who does not maintain a consulting relationship whereby a mental health professional accepts full professional responsibility. However, ~~MA~~ medical assistance shall reimburse a mental health

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

practitioner who maintains a consulting relationship with a mental health professional who accepts full professional responsibility and is present on site at least for one observation during the first twelve hours in which the mental health practitioner provides the individual, family, or group skills training to the child or the child's family.

Thereafter, the mental health professional is required to be present on-site for observation as clinically appropriate when the mental health practitioner is providing individual, family, or group skills training to the child and the child's family. The observation must be a minimum of one clinical unit. The on-site presence of the mental health professional must be documented in the child's record and signed by the mental health professional who accepts full professional responsibility.

H. home-based mental health services by more than one mental health professional or mental health practitioner simultaneously unless prior authorization is obtained.

I. home-based mental health services to a child or the child's family ~~which~~ that duplicate health services funded under medical assistance mental health services, grants authorized according to the Minnesota Family Preservation Act, or the Minnesota Indian Family Preservation Act. However, if the mental health professional providing the child's home-based mental health services anticipates the child or the child's family will need outpatient psychotherapy services upon completion of the home-based mental health services, then one session of individual psychotherapy per month for the child, or one session of family psychotherapy per month for the child and the child's family, is eligible for medical assistance payment during the period the child is receiving home-based mental health services. For purposes of the child's transition to outpatient psychotherapy, the

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

child may receive two additional psychotherapy visits per six month episode of home-based mental health services if the mental health professional providing the home based mental health services requests and obtains prior authorization. Additional outpatient psychotherapy services provided concurrent with home-based mental health services in excess of these limits are eligible for ~~MA~~ medical assistance with prior authorization. In addition, up to 60 hours of day treatment services provided concurrently with home-based mental health services to a child are eligible for ~~MA coverage~~ medical assistance payment if the child is being phased into home-based mental health services, or if the child is being phased out of home-based mental health services and phased into day treatment services and home-based mental health services and day treatment services are identified with the goals of the child's individual treatment plan. Additional day treatment services provided *concurrent* with home-based mental health services in excess of these limits are eligible for ~~MA~~ medical assistance payment with prior authorization.

J. home-based mental health services provided to a child who is not living in the child's residence. However, up to 35 hours of home-based mental health services provided to a child who is residing in a hospital, group home, residential treatment facility, regional treatment center or other institutional group setting or who is participating in a partial hospitalization program are eligible for ~~MA~~ medical assistance payment if the services are provided under an individual treatment plan for the child developed by the provider working with the child's discharge planning team and if the services are needed to assure the child's smooth transition to living in the child's residence. Additional home-based

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

mental health services provided *concurrent* with inpatient hospital services in excess of these limits are eligible for ~~MA~~ medical assistance with prior authorization.

2. **Day treatment services for mental illness** for children are limited to:

A. Services recommended by a psychiatrist, licensed psychologist, licensed independent clinical social worker, ~~or a~~ registered nurse with a master's degree and certificate from the American Nurses Association as a clinical specialist in psychiatric nursing or mental health, licensed psychological practitioner, or licensed marriage and family therapist with at least two years of post-masters supervised experience;

B. Services supervised by an enrolled psychiatrist or other mental health professional listed in item 6.d.A.;

C. Services provided in one of the following settings:

1. Joint Commission on the Accreditation of Healthcare Organizations approved outpatient hospital;
2. Community Mental Health Center;
3. County contracted day treatment provider.

D. Services provided no fewer than one day per week and no more than five days per week;

E. Services provided for three hours of day treatment per day; and

F. No more than one individual or one family session per week when in day treatment.

G. Services that, when provided to the family, are directed exclusively to the treatment of the recipient.

4.b. Early and periodic screening, diagnosis, and treatment services: (continued)

Services in excess of these limits are eligible for ~~MA~~ medical assistance with prior authorization.

**3. Psychotherapy services** for children ~~as follows:~~ . Psychotherapy services require prior authorization as specified in the *State Register*.

| Services | Limitations |
|---|---|
| individual psychotherapy, 20 to 30 minutes ~~(90843)~~ | ~~90843~~ Individual psychotherapy and one half hour units of ~~90915~~ biofeedback training combined, are covered up to 26 hours per calendar year~~, unless additional coverage is prior authorized~~ |
| individual psychotherapy; 40 to 50 minutes ~~(90844)~~ | ~~90844~~ Individual psychotherapy and one hour units of ~~90915~~ biofeedback training combined, are covered up to 20 hours per calendar year~~, not more frequently than once every five calendar days, unless additional coverage is prior authorized~~ |
| family psychotherapy without patient present ~~(90846)~~ | up to 20 hours per calendar year when combined with ~~90847~~ family psychotherapy~~, unless additional coverage is prior authorized~~ |
| family psychotherapy ~~(90847)~~ | up to 20 hours per calendar year when combined with ~~90846~~ family psychotherapy without patient present~~, unless additional coverage is prior authorized~~ |